DRS Care Homes Limited

Number Residential Care Home

Inspection report

45-47 Pembury Road
Tottenham
London
N17 6SS

Tel: 02088014860

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected this service on 2 February 2016. The inspection was unannounced. Number Residential Care Home is a care home registered for a maximum of ten adults. Some of the people living there had long term mental health needs, some with additional disabilities.

At the time of our inspection there were ten women living at the service. The service is located in two adjoining terraced houses, on two floors with access to a front and back garden. We previously inspected the service on 6 August 2014 and the service was found to be meeting the regulations inspected.

Number Residential Care Home had a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People using the service informed us that they were happy with the care and services provided. During the inspection we saw staff were caring, kind and compassionate and treated people with dignity and respect.

Care records were individualised, contained people's personal histories and reflected their choices, likes and dislikes, and arrangements were in place to ensure that these were responded to. Care plans provided detailed information about people's mental health needs which were closely monitored. Risk assessments had been carried out and updated regularly. These contained guidance for staff about protecting people. Staff were able to tell us about the needs of people they cared for and were aware of the most effective way of supporting them with their mental health needs.

People were supported to maintain good health through regular access to healthcare professionals, such as the local mental health team and GPs. We saw people had access to opticians and dentists on a regular basis.

People's cultural and religious needs were facilitated by staff.

People had their medicines managed safely, and they received their medicines as prescribed. Storage and management of medicines was safe with clear systems in place.

Staff had been carefully recruited and provided with training to enable them to care effectively for people. Staff felt supported and there was evidence of regular supervision taking place in recent months. Staff knew how to recognise and report any concerns or allegations of abuse and were able to tell us what action they would take to protect people against harm. Staff knew what whistleblowing was and were able to tell us what they would do if they were concerned about the quality of the service.

There were enough staff to meet people's needs and management of money for people using the service

was safe.

We found the premises were clean and tidy, and measures were in place for infection control. There was a record of essential services such as gas and electricity being checked, with fire drills taking place regularly. There was clear documentation relating to complaints and incidents.

Staff told us the management was a visible presence within the home, and the staff we met were caring, kind and compassionate.

There was a wide age range of people living at the service. The provider focused on the compatibility of people living at the service and prioritised this when considering new admissions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Risk assessments were very comprehensive and gave staff guidance as to what action to take to prevent or minimise harm to people using the service.

People received their medicine safely and on time.

Appropriate checks and references were taken prior to staff starting work to ensure they were considered safe to work with vulnerable people.

Is the service effective?

Good

The service was effective. There was evidence of people accessing health care including optician and dentistry services.

Regular supervision took place with staff and suitable training was provided.

People were supported to eat a healthy diet.

Is the service caring?

Good

The service was caring. Staff we spoke with were able to tell us about the people they cared for, their likes and dislikes. We saw they were caring in their interactions with people and this was confirmed by people using the service.

Care documents noted people's cultural and religious needs and how these should be met.

People were involved in the planning and giving of care at the service.

Is the service responsive?

Good

The service was responsive. Care plans were individualised and updated regularly and identified goals people wanted to achieve.

Complaints were dealt with appropriately, although there was only one complaint logged in the last 12 months.

People were encouraged to come for visits and overnight stays prior to joining the service to ensure it could meet their needs and they were compatible with the existing residents.

Is the service well-led?

Good

The service was well led. Quality assurance audits took place to ensure the building was well maintained and the standard of care was good.

The registered manager provided good leadership and had undertaken surveys to obtain the views of people living at the service, staff and relatives and professionals visiting the service in the last 12 months.

Number Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 February 2016 and was unannounced. It was undertaken by two inspectors for adult social care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about significant events which the service is required to send us by law.

During the inspection we met and spoke with two people who lived at the service. The other eight people chose not to talk with us. We spoke with five members of staff including the registered manager/provider and the area manager. After the inspection we spoke with two relatives and two health and social care professionals who visited the service on a regular basis.

We also looked at five care records related to people's individual care needs, five staff recruitment files including supervision and staff training records. We looked at the records associated with the management of medicines. We reviewed documentation related to essential services and documents relating to the management of money.

As part of the inspection we observed the interactions between people and staff and discussed people's care needs with staff. We also looked around the premises.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home . One person told us " The exits are pretty much safeguarded, they have curtains at the window. There is always someone around especially in the dining area." Another person told us "I can't make a drink as I nearly scolded myself on the kettle so I ask (a staff member) and she does it."

We noted the provider had not had any safeguarding concerns in the past year. However staff were aware of their responsibility to safeguard adults, and were aware of the reporting procedures if they had any concerns about a person's safety. Staff were also aware of the types and signs of any abuse that might occur. The registered manager told us they and all staff had attended training on safeguarding adults from abuse and staff training records we saw confirmed this.

Staff were aware of the whistleblowing policy and procedures, and felt comfortable to use them if they felt it necessary. We were able to read the provider's policy and procedures on safeguarding and whistle blowing. We found them to have detailed information on what to do in the event of concerns regarding the service.

Medicines were administered safely. We looked at the medicines folders which were clearly set out and easy to follow. They included information on an individual's medicines, details of their GP, information about their health conditions and any allergies. They also included the names, signatures and initials of staff qualified to administer medicines. Staff we spoke with could describe how to administer medicines safely, and training records showed they had completed the appropriate training. People living at the service could tell us what their medicines were for and one person was able to tell us what the side effects were.

We checked the balances of medicines stored in the cabinets against the medicine administration record for four people and found these records were up to date and accurate, indicating people were receiving their medicines as prescribed by health care professionals.

Individual assessments were undertaken to identify the risks to people and others. These assessments were undertaken in conjunction with information obtained from people's associated professionals, family and the person themselves. For each risk identified an action plan had been developed which explained how to manage and minimise it. Risk assessments and associated action plans incorporated triggers and de-escalation techniques. The action plans were concise and clear and staff told us they were aware of each person who used the service and understood any risk there may be and how to minimise the risk.

Staff identified promptly if people were displaying signs that their health was deteriorating and supported people appropriately, together with their allocated social worker or mental health professional.

Staff learnt from incidents that occurred at the service. Accidents and incidents were recorded and were up to date. We noted there had not been any for eight months. The provider had a system which analysed each incident and we saw there was an action plan initiated to minimise the risk of a repeat of any accident.

Staff files contained copies of references, photo identity, evidence of the person's right to work and Disclosure and Barring Service checks. They contained a completed application form and documents demonstrated why the individual had been employed or not, and whether they held the appropriate knowledge and skills necessary to do the job. All this information meant staff were considered safe to work with people who used the service. Staff files included a section on staff disciplinary procedures where any had taken place.

One person told us "More often than not there is staff available you can talk to." On the day of the inspection there were sufficient staff to meet people's needs. We saw from the rota that staff were available 24 hours a day. There was two care support staff on duty during the day with ten people who used the service. In addition, one person had one to one care between 9am and 5pm. The registered manager told us that staffing could be increased according to people's needs, or to support people to appointments as necessary. Most people went out without support. Shifts were organised so there was enough time for a 15 minute handover of information between staff to enable continuity in care and support provided. Staff told us a senior manager was always on call. As the provider had other schemes locally, there were usually enough staff employed to cover any emergency such as staff sickness. Otherwise, there were bank staff that could be called in as needed.

The provider only managed the money for one person at the service. Records showed the money held tallied with the records and receipts were available and stored to evidence expenditure.

To promote people's security, the service had a CCTV system, which recorded outside the building and the surrounding perimeter.. Checks were carried out to ensure the buildings and equipment were safe for people to use. The building was clean, food was stored safely and hygienically. A broken door on the cupboard in the garden in which paints were stored was fixed whilst we were carrying out the inspection.

We saw that there was a business continuity plan in place for dealing with emergencies that could affect the home, such as flood, fire or loss of power. A place of safety had been identified should evacuation be necessary and planned evacuations of the building were completed monthly.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager was able to clearly explain and evidence the process. The provider had a check list which indicated whether a person might fit the criteria for DoLS. If so the provider completed a capacity assessment on the area in question. If it was felt the person lacked capacity a referral was immediately made to the appropriate local authority. Staff understood the principles of the MCA and were clear about the need for consent prior to offering any care.

People told us they were able to make choices around their care and support. One person told us "They implement their own ideas as well as my own", for example, "I wanted the layout of my clothes in the wardrobe a particular way and they listened to me". We also saw that for those people who had capacity to make decisions and choices that they had signed their own treatment plans and assessments to show they understood.

We asked the registered manager how the service might work with people who used the service who did not have the capacity to be able to make choices for themselves. The registered manager explained there was one person who had been the subject of a recent DoLS application. We were told all the people living at the service were free to come and go as they wanted and deemed to have capacity to make decisions.

Staff we spoke with had a clear understanding of the MCA and of DoLS. We noted when reading the provider's training matrix that all staff had attended the relevant training and the training was reviewed annually.

Health and social care professionals, whilst noting the good service provided, told us that they felt at times there was a slightly over protective approach adopted by the staff. For example, two people who were deemed to have capacity to make decisions were encouraged to have support workers with them when they went out due to safety reasons. The registered manager told us that where people have complex needs there is a balance between their exposure to harm in the community and their personal freedom with the provider also having to exercise a duty of care. Not everyone had a key to the house although we were told people could come and go as they wanted. The registered manager told us that individual's situations, including whether they had or wanted a key, were continually reviewed, incorporating the views of the individual, the commissioner of the service and other key people in the person's life including professionals.

Staff told us they had undertaken induction training delivered by the provider when they started work at the service, and they had shadowed experienced staff as part of the induction process. The registered manager told us the provider had initiated the new induction standard as set by "Skills for Care." Staff told us the training equipped them with the information and skills needed for their roles. One person living at the service told us '"They [the staff] are very attentive and will use their better judgement to guide you".

Staff also told us the provider organised regular training updates in key areas. The registered manager had a record of all staff training and when updates were due. Training was ongoing in areas such as first aid, working with behaviour which challenged, moving and handling, skin care, diet and nutrition and food hygiene. All staff were encouraged to develop themselves and undertake additional health and social care qualifications to support their work. This meant that staff were given the guidance they needed to support them to care for the people who lived in the home.

We spoke with three members of staff about supervision and appraisal. We looked at the records which showed staff members received an annual appraisal and regular supervision. One staff member told us: "The supervision is good; I can speak or ring the (registered) manager anytime if I have a problem." Another member of staff told us: "I've had regular supervision meetings since I started work here." This showed there was regular support for staff members. We saw that staff received suitable professional development and were supported to deliver treatment safely and to an appropriate standard.

Staff told us how they managed people when they were displaying behaviours that can be challenging. We saw the registered manager diffuse an incident very swiftly and effectively during the day of the inspection as she understood that our presence was very unsettling for one person.

People's food preferences and needs were recorded and menus planned to reflect this. The staff provided for specific diets based on health and cultural needs and personal preferences. Food was freshly prepared by the staff each day and people had a choice of different meals. The kitchen was appropriately stocked with fresh food and fruit. However, one person told us they didn't always feel a range of snacks were available. The registered manager said they would have a standing item of food/menus at the meeting for people who lived at the service, as whilst she told us it was regularly discussed, this was not recorded in the minutes.

We saw that people had access to specialists and professionals such as psychiatrists, opticians, physiotherapists, occupational therapists, dentists and chiropodists. Each person had a GP who they saw when needed. Any risks to people's health and wellbeing were identified and managed appropriately in order to promote their safety and prevent health problems. Care plans were reviewed and updated on a regular basis so that staff had up to date information about the health care needs of each person. Records were kept of all appointments and visits with health professionals.

Good

Is the service caring?

Our findings

People we spoke with told us staff were caring to them. One person told us "I had a really bad muscle pain in my back and staff rubbed my back and helped it go away." Another person felt the staff were caring as "they comb my hair." We saw staff interacting well with people using the service and it was clear they knew what people liked and didn't like and how to relate to people.

Relatives we spoke with were very positive about the caring nature of the staff. One relative commented on the patience displayed by staff. They also told us how personalised and pleasant the person's bedroom was, and we saw this for ourselves during the inspection visit. One person told us of the service "I get weekend leave to be with (a relative), this is my second home."

Staff told us they ensured people had privacy and they treated them with dignity and respect in a number of ways. For example, they knocked on people's doors and waited to be invited in. One person told us "When using the shower they don't prod or watch you they wait outside until you are finished."

We saw from care records that people were involved in their care as care plans and key worker sessions were signed by people living at the service. One person told us "I am involved with the care plan. A worker will fill out a form and they ask me questions about my goals and what I want from it." They also said that "If they think you need more time (to make a decision) they usually give it."

Agreement to share information forms were completed on files so the service had permission to talk with health professionals and family members regarding a person's health and well-being. This meant people had some control over the sharing of private and personal information.

We saw from care records and discussions with staff that they were aware of how to support people's cultural and religious needs. One care plan noted the importance of particular hair products for one person, and they were supported to cook their favourite foods on a regular basis. Another care plan noted a person could understand English, and could speak it in a limited way, but would need an interpreter for important meetings. One Muslim person living at the service had Halal meat purchased for them, and there were several fridges to facilitate the separation of food if this was required.

Some people living at the service had partners. Staff were supportive of people having a relationship if they wanted to and they were welcome to visit the home, but were not allowed to stay overnight.

Each care record had a section on end of life preferences which meant that the staff had some awareness of what people would like to happen in the event of their death. This was particularly important for some people who had no friends or relatives involved in their life.

Good

Is the service responsive?

Our findings

Care plans were comprehensive, person centred and up to date. They covered a wide range of areas including people's ability to carry out activities of daily living, finances, ability to take medicines by themselves. They also covered people's religious and cultural needs and contained pictures as prompts for some people using the service. For example, there were photographs of the opticians shop and the buildings the GP and chiropodist were located in. This helped some people understand their care plan better.

We saw Health Action Plans and Person Centred Plans were also in place so there was a lot of detailed information on people's health and the ambitions or goals they wanted to achieve. The organisation used a holistic tool which looked at all areas of a person's life, including employment, relationships and home as well as health and well-being. Catch up sessions with a named staff member took place monthly. These provided an opportunity to discuss holistic objectives with people and paperwork was updated as a result.

People living at the service were deemed to have the capacity to leave the service unaccompanied and decide what leisure/volunteering/study opportunities they wished to take up. Staff encouraged people to participate in activities in the local community. Some people chose to go to cafes or shopping regularly; others swimming, or to the gym. One relative was particularly happy with the range of activities on offer for their relative. One person chose to do very little except go for a walk to the local shops. The registered manager explained that the staff actively encouraged more participation but it was important to listen to people's choices and not doing so impacted on their mental well-being and increased behaviours that challenged. One relative we spoke with told us the staff were actively working to increase a person's independence in relation to both domestic tasks and moving around safely outside the service.

The service commissioned a yoga teacher to run a session once weekly at the house. This was regularly attended by three people and it was clear they had become very flexible from this regular activity. This was evidence of the provider creatively solving the need for exercise for people living at the service. Other activities in the home included playing board games and watching a film. One person told us they would like to make more jewellery at the home. A relative told us they were happy with the support with activities their relative received.

The registered manager told us she was considering how to support people to have meaningful activities particularly as many local facilities for people with specific needs were no longer available. This was a discussion she would continue to have with staff and with people living at the service through key worker sessions and monthly 'residents meetings'.

We saw on records that many people had gradually transitioned into the service through day visits and overnight stays. The registered manager explained that compatibility of people living at the home was a priority when considering new admissions, to minimise triggers for behaviours that challenge. Staff understood who liked to be involved in group activities, who needed to be left alone and their support was managed accordingly.

We looked at the complaints file which only contained one complaint in the last 12 months. This had been dealt with promptly and appropriately. Relatives commented on how responsive the registered manager and staff were to any comments or issues they raised. One relative told us I have never had to complain but I know how to. One person told us "there is a new complaints box on the wall. The (registered) manager opens it every two weeks….but I would go to the (registered) manager or talk to staff."

Good

Is the service well-led?

Our findings

The organisation had a philosophy underpinning it's work "from possibility to actuality." Each person had a brochure for 2016 in their care files and copies were available for their rooms. This gave information about the organisation, facilities in the local area and the complaints process.

We saw records of staff meetings and meetings for people who lived at the service. These took place on a monthly basis and covered a range of issues. The registered manager planned to put a standing agenda item of food/menus for the meeting for people living at the service to ensure there continued to be an ongoing discussion regarding the menu.

The registered manager had conducted three surveys anonymously in the last 12 months in order to gain the views of the people using or visiting the service, including relatives and professionals, and the staff. We saw that six staff members six external professionals or relatives and all the people living at the house had completed questionnaires.

One hundred percent of the staff who completed the questionnaires rated the supervision received as either excellent or very good; with 67% reporting support with staff issues as either excellent or very good and the remaining 33% as good. Staff also felt involved in changes in the home as 83% rated this as either excellent or very good, and 100% of staff were fully aware of the complaints and whistleblowing policy.

People living at the service rated most highly the support they received from staff, that they had access to their records, that they were supported to be independent, that their cultural and religious needs were respected and that staff were polite, caring and kind to them. Areas that the registered manager identified to take forward were more support to: understand staff role and responsibilities; take part in local community activities; encouragement for people to take part in regular residents meetings and for staff to ensure concerns were dealt with quickly. One person living at the service told us the service is "very professional" and there are "pretty good systems here, it's well run". Asked if they would recommend the home to anyone else they replied "Yes, if [they] needed care. I like it here."

The survey of professionals, relatives and friends of people living at the service returned very positive scores in a number of areas including involvement in care planning, the overall standard of care and the atmosphere of the care provision.

These surveys illustrate a willingness to hear from people involved in or with the service and the registered manager told us this information had informed some changes. For example, the dates and timing of meetings for people living at the service was changed to maximise attendance; and as communication was identified as an issue for the staff team, specific communications training was booked for February 2016. To facilitate better communication for all a box has been installed near the front door for all suggestions, compliments and complaints. The organisation has also employed additional administrative staff in the last six months to assist in improving communication internally and with people external to the organisation.

Quality assurance audits took place in key areas such as infection control, medicines management and care records. These ensured documents relating to care and medicines were up to date and accurate, and the home remained clean throughout. Where remedial action was identified we saw it was followed up.

The registered manager had systems to ensure checks in relation to gas, electricity, portable appliance testing and fire safety equipment had taken place in the last 12 months. These were important to ensure the building was maintained and safe for use.